MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 FAX (916) 263-2567
www.mbc.ca.gov

DISABLED PHYSICIAN APPLICATION FOR EXEMPTION FROM PAYMENT OF RENEWAL FEE

NO PRACTICE PERMITTED

Please print or type.
Illegible applications will be returned.

FOR OFFICE USE ONLY

Fee Paid:_____ Receipt #:_____

Date Cashiered:_____ Cashier's Intl.: _____

Management Approval:_____ Denial_____Date:_____

Enforcement Approval: Yes_____No_____ Date:_____

Name (first, middle, last):	
Address: This address will be on file with the Medical Board of California and is public information. If providing a post office box, you must also list a confidential street address**.**	
Telephone Number: **FAX Number (if applicable):**	Telephone ( ) FAX ( )
Social Security Number:	
California Medical License Number:	

THE FOLLOWING MUST BE COMPLETED BY YOUR ATTENDING PHYSICIAN.

Description of disability and explanation as to how the disability prevents the applicant from practicing medicine safely. (Attach additional sheet(s) if necessary.)

_____

_____

Approximate date disability began:_____ The disability is: Temporary_____ Permanent_____

If "Temporary," approximate date applicant will be able to return to practicing medicine:_____

Attending Physician's Name:_____ Telephone Number:_____

Attending Physician's Address_____ City_____State_____Zip_____

I certify under penalty of perjury under the laws of the State of California that the information I have provided in this application, including any supporting documents, is true and correct and that I am licensed to practice in the State of California.

Applicant's Signature_____ **Date**_____

I certify under penalty of perjury under the laws of the State of California that the information I have provided in this application, including any supporting documents, is true and correct and that I am licensed to practice in the United States of America.

Attending Physician's Signature_____ **Date**_____

Attending Physician's License Number_____ **State Attending Physician is licensed** _____

All items in this application are mandatory; none are voluntary. This information is requested by the Division of Licensing of the Medical Board of California. Failure to provide any of the requested information may result in this application being rejected as incomplete. The information will be used to determine your eligibility for your waiver of renewal fees, pursuant to Section 2441 of the Business and Professions Code. The Licensing Program Chief is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at the above address. Information in this application may be transferred to other governmental or law enforcement agencies.

Disclosure of your Social Security Number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Section 30 of the Business and Professions Code and Public Law 94.455 (42 USCA 405(c)(2)(C)) authorize collection of your SSN. Your SSN or FEIN will be used for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

BOTH PAGES OF THIS FORM MUST BE COMPLETED

FINANCIAL INTEREST STATEMENT

California's Financial Interest Disclosure law (Business and Professions Code section 2426) requires you to disclose any financial interest that you or your immediate family have in specified health-related facilities located in or outside the State of California. Immediate family means a spouse, child or parent of a licensee, and a spouse of a child of a licensee.

Financial interest includes any type of ownership interest including share of stock ownership, limited partnership interest, loan, lease, compensation, remuneration, general or limited partnership interest, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment of money or anything else of value to a licensee or the licensee's immediate family from a health-related facility.

Health-related facility means any facility that provides clinical laboratory services, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, diagnostic imaging, or outpatient surgery centers. Diagnostic imaging includes all x-ray, computed axial tomography, magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography and ultrasound goods and services.

A financial interest does not include the ownership of corporate investment securities, including shares, bonds, or other debt instruments that (1) are purchased from a licensed securities broker on terms available to the general public through a licensed securities exchange or NASDAQ, (2) do not base any profit distributions or other transfers of value on the licensee's referral of patients, (3) does not have a separate class or accounting for any persons or licensees who may make patient referrals to the corporation, and (4) are in a corporation which has total gross assets exceeding $ 100,000,000.

Health-Related Facility Name(s)	Facility's Address

I certify under penalty of perjury under the laws of the State of California that I read and understand the information defining financial interest and that I have disclosed on this application the names of those health-related facilities in which I or my family have a financial interest.

Applicant's Signature_____Date_____
Note: If no financial interest, please sign, date, and indicate "NONE."

CME CERTIFICATION STATEMENT

In order to insure the continuing competence of licensed physicians and surgeons, the Division of Licensing shall adopt and administer standards for the continuing education of such licensees. The division shall require each licensed physician and surgeon to demonstrate satisfaction of the continuing education requirements at intervals of not less than four nor more than six years.

I certify under penalty of perjury under the laws of the State of California that I read and understand the continuing medical education (CME) requirements, have completed and can document (if audited) an average of 25 hours of approved CME each calendar year, with 100 hours over the last 4 years or that I hold a CME waiver from the Medical Board of California.

Applicant's Signature_____Date_____

INFORMATION AND FILING INSTRUCTIONS

Section 2441 of the Business and Professions Code provides an exemption from payment of a renewal fee if a licensee demonstrates to the satisfaction of the Board that the licensee is unable to practice medicine due to a disability. This waiver is at the discretion of the Board, may be terminated at any time, and is based on the licensee's inability to practice medicine.

The licensee and his or her attending physician are required to complete the application. If the application is approved, the license will denote "Disabled." Biennially the licensee will receive a "License Renewal Application" to complete and sign, but no fee will be required to renew this exempt license. **The holder of a disabled license cannot engage in the practice of medicine.**

At the time of application, if the applicant's physician's and surgeon's license is expired, payment of all accrued renewal fees, the delinquent fee, and penalty fee must be submitted with the application. If the applicant's physician's and surgeon's license has not expired, no fee is required.

When a licensee desires to return to practicing medicine, the licensee and attending physician will be required to complete an application to have the licensee removed from disabled status and returned to "active" licensure. It must be established to the satisfaction of the Board that the disability either no longer exists or does not affect the licensee's ability to practice medicine safely. At the time of application, the licensee must also submit payment of the current (active license) renewal fee.

The holder of a disabled license must comply with the Continuing Medical Education (CME) requirements, unless the holder has also applied for and been granted a CME waiver. If you wish to apply for a CME waiver, please contact the Board for appropriate forms.

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Application Coordinator	Medical Consultant
Applicant's License Verification: License Number:_____ Issue Date:_____ Expiration Date:_____ Enforcement Date:_____ **Attending Physician License Verification:** License Number:_____ Issue Date:_____ Expiration Date:_____ Enforcement Date:_____	Approved_____Denied_____ If denied, please provide reason: _____ _____ _____ _____ _____